December 10, 2018

Marlene H. Dortch, Secretary
Office of the Secretary
Federal Communications Commission
445 12th Street SW
Washington, DC 20554

Re: **Feasibility of a 3-Digit Number for Mental Health and Suicidal Crises**, WC Docket No. 18-336, CC Docket No. 92-105

Dear Madam Secretary:

Vibrant Emotional Health appreciates the opportunity to comment on the feasibility and need for a 3-digit number for mental health and suicidal crises. For 50 years, Vibrant Emotional Health (formerly the Mental Health Association of New York City doing business as Vibrant Emotional Health) has been at the forefront of promoting emotional well-being. In addition to running innovative community programs, we run state-of-the-art crisis lines like the National Suicide Prevention Lifeline, NYC Well, the Disaster Distress Helpline, and the NFL Life Line. Our advocacy and education work strives for systemic change. This hands on experience gives us a unique understanding of the issues people face every day.

As administrators of premiere local and national crisis hotline services for over 20 years, Vibrant can attest to the power and potential of how a single number can promote access to life-saving behavioral health and suicide prevention services. Crisis centers save lives, and their impact cannot be overstated. However, their utility is limited by their accessibility, and therefore we strongly recommend that an easy-to-remember, 3-digit dialing code be used for a national suicide prevention and mental health crisis hotline system.

We emphasize, though, that it is equally important that these centers are provided the resources needed to serve our communities. Accordingly, we strongly recommend that the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Department of Veterans Affairs (VA) work with the National Institute of Mental Health (NIMH) to create a working group to analyze and estimate the costs and resources needed to fully support the local and national crisis services infrastructure resulting from implementation of a 3-digit crisis number. We further recommend that public health authorities, locally and nationally, collaborate to provide the resources required to implement and maintain this system. We recognize that these matters are not within the Commission's purview, but as an essential starting point, there is no question that there is need for an easily recognizable 3-digit number for suicide prevention and mental health crisis on a nationwide basis, and that the deployment of such a number will not only further the health of all Americans, but will indirectly contribute to public safety by freeing up 911

and other emergency numbers for the purposes for which these numbers were intended and are able to serve.

I. The Need for a 3-Digit Mental Health and Suicide Crisis Number Is Indisputable

The Centers for Disease Control and Prevention (CDC) reports a 33% increase in suicides from 1999 through 2017 with 2017 suicides rising at an alarming 3.7% higher rate than 2016. Since 2008, suicide has ranked as the 10th leading cause of death for all ages in the United States. In 2016, suicide became the second leading cause of death for ages 10–34. *NCHS Data Brief No. 330*, (November 2018).

These trends are alarming. Suicide presents a major challenge to public health in the United States. It contributes to premature death, injury, lost productivity, and health care costs. Suicide and suicide attempts also have far reaching consequences for friends, families, and communities. In one study cited by the CDC, 48% of the population knew at least one person who died by suicide in their lifetime. *Preventing Suicide: A Technical Package of Policy, Programs, and practices*, (2017).

Like many public health problems, suicide is preventable. While there is no single solution to the problem, the National Suicide Prevention Lifeline and local crisis centers are proven components in suicide prevention. Independent evaluations of the service have shown consistently that the service is effective in reducing emotional distress and suicidality in callers, with 12% of suicidal

callers spontaneously informing the evaluators that the call "saved my life." The evaluations also found that about 25% of callers presented with suicide-related concerns, with many others reporting non-suicidal mental health crises. The Vibrant-operated NYC Well (also a Lifeline center) will answer over 350,000 contacts this year for NYC persons with mental health and suicidal concerns, with 30% having no prior history of mental health treatment. These programs are reaching people whom our traditional clinical care systems are not currently serving.

However, these centers are not reaching everyone in need of help and crisis service. National surveys by the CDC and SAMHSA indicate that approximately 12.6 million people think seriously about suicide *each year*. To achieve and sustain substantial reductions in suicides and attempted suicides, it is necessary to increase the visibility and accessibility of these services. In our partnership with the Veterans Administration since their suicide hotline was launched in 2007, the service saw a marked increase in calls when they changed the name of the service from The Veterans Suicide Prevention Hotline to the Veterans Crisis Line in 2009.

Providing an easy-to-remember, 3-digit number for persons to call in mental health or suicidal crisis would significantly increase access to care. Studies demonstrate that crisis states impede thinking and memory, and long-term memory works optimally in chunks of 3. Research from the U.K. published in 2011 noted that the most important suicide prevention strategy

they employed was the establishment of a 24/7 crisis service. And in 2015, the U.K. National Health Service established a 24/7 3-digit number (111) to help triage emergency health and mental health needs. Calls increased by 3 million in one year after implementation of the 3-digit number. Given the research showing the efficacy of Lifeline network crisis center service in reducing emotional distress and suicidality, it is expected that increasing access to this vital service would reduce distress and suicidality in the population markedly.

II. 3-Digit Calling Enhances Public Safety

A 3-digit dialing code for suicide and mental health would also enhance public health and safety by diverting mental health calls from the existing 911 system, saving countless resources in emergency response and other law enforcement resources. Many 911 centers report receiving non-urgent mental health calls, and a significant number these calls could be effectively de-escalated by trained crisis counselors.

Lifeline member centers are effective in de-escalating persons in suicidal crisis whom might otherwise be diverted to emergency services. SAMHSA-funded evaluations found that 75% of callers at the highest risk of suicide were effectively de-escalated through crisis counselor interventions on the phone, with 40% requiring no emergency services response. Through the appropriate use of evidence-based crisis intervention, deployment of mobile crisis teams, and other resources, high risk callers can often remain safe

without the unnecessary use of law enforcement and/or emergency medical service teams.

Establishing a 3-digit dialing code would also help reduce the stigma towards mental illness and suicide prevention efforts in America. The act of establishing the 3-digit number itself would demonstrate the importance and need for suicide prevention, serving to encourage those in crisis to seek help. It is also expected that a number for both mental health and suicidal crises will have the advantage of reaching more distressed persons upstream, before they are suicidal, as well as people who may be more prepared to talk about their "mental health crisis" than their suicidal thoughts. Implementing a 3-digit number would also underscore the different approaches, resources, and care needs required to address these problems, different from 911 and the typically inappropriate use of law enforcement or EMS to address these needs.

As the organization that administers the Lifeline, we are dedicated to ensuring both efficient connection to and effective care from crisis counselors. Providing a 3-digit number for mental health and suicidal crises will coincide with our mission to promote greater access to care for all.

III. 911 or 211 Alone Are Inadequate: A New 3-digit Dialing Code Is Needed on Existing Lifeline Network Infrastructure

The Lifeline's national network infrastructure is ideally suited to be scaled to assist with the specialized needs of person in mental health and suicidal crisis. In operation since 2001 (as the Hopeline network from 2001-

2004), all centers are certified and have adopted Lifeline's evidence-based best practices for suicide prevention. These best practices and specialized trainings at Lifeline member centers make a difference. A study by RAND in 2016 of ten California crisis centers found that callers to the Lifeline network centers were more likely to be assessed for suicide and report reduced distress by the end of the call than non-Lifeline centers. In addition, the centers are well equipped to reduce overall distress of callers with non-suicidal mental health crises, as found in a SAMHSA-funded evaluation of centers (2007).

First, the Lifeline's network of local crisis centers is structured to ensure that callers are routed first to the center nearest to them, to enable optimal area-specific crisis/emergency and/or treatment/support service linkages, if needed. The 2018 network survey found that all centers provide local information and referrals to behavioral health treatment and support services, and nearly all have formal or informal relationships with local crisis and emergency services. Second, callers are routed to national back-up centers to ensure that all calls are answered, if the local centers are unavailable to rapidly respond to the call. This "back-up" capability is vital for any and all crisis call center services, in the event of unexpected call surges and/or service interruptions.

By contrast with 211 services, Lifeline's network consolidates the local resource knowledge and capability with the vital specialization of working with callers in crisis. Only 40 of the more than 200 non-networked local 211

information and referral services across states also specialize in crisis intervention and suicide prevention. All 40 of these "blended centers" are in the Lifeline network. A dedicated 3-digit code for mental health and suicidal crises linked to the Lifeline network of centers will: (a) enable persons in mental health crisis that call either a local or national crisis hotline number to reach the same expert local service; and (b) prevail upon the existing expertise of the 20% of 211 centers that have adopted Lifeline's best practices in suicide prevention. In this case, the 20% of Lifeline/211 centers can answer calls to both 211 and the new 3-digit hotline number, while the remaining 80% of 211 centers that do not specialize in crisis care can continue to answer only 211 calls, allowing them to concentrate on their area of information and referral expertise.

Any infrastructure connected to a new 3-digit dialing code for persons in mental health or suicidal crisis will need to work collaboratively with both 211 and 911. This is why the current Lifeline network (and Vibrant, specifically) has developed strong working relationships with both 211-United Way and the National Emergency Number Association (NENA). In the event a new 3-digit number is assigned, we will all need to work in tandem to optimize services interoperability as well as develop public health promotional strategies, to enhance public awareness about the different functions of each of these 3-digit numbers.

IV. Proceed with 3-Digit Dialing, But Evaluate the Costs of the Infrastructure Support Required

As Administrators of the Lifeline network, we are well aware of the importance of properly resourcing crisis services so they have the capacity to manage growing call volume. For example, the Poison Control network reports receiving about $160 million annually to respond to about 3 million calls annually, and the Veterans Crisis Line receives over $90 million to respond to the needs of veterans in mental health and suicidal crisis. Because these services are properly resourced, they can provide sufficient, rapid response to increasing volumes of callers in crisis. By contrast, the Lifeline network receives approximately $10.7 million in federal funds annually, which is not intended to fund specifically the local centers' staffing to answer calls. The reliance on variable local funding resources can effect wait times for callers on the national Lifeline, especially in parts of the country where community crisis centers are not funded to answer local calls coming through the national number.

The SAMHSA-funded Lifeline's national network of local crisis centers answered more than 12 million calls in its first 12 years since launching in 2005. We project that the network will answer another 12 million calls in the next 4 years alone. As calls have increased to the Lifeline over the years, we have also seen that public health supports have not sufficiently addressed the resource needs for the local crisis centers answering Lifeline calls and the

network overall. It is essential that any effort to successfully enhance public access to mental health and suicide prevention assistance also receive resource support commensurate with anticipated demand.

Because it is expected that a 3-digit number would effectively promote access to care for persons in mental health and/or suicidal crisis, it is vital that resource needs for supporting the network infrastructure be in place. We strongly recommend that SAMHSA, the VA and/or NIMH create a task force to research, analyze and determine reasonable cost needed to support such a program before a national 3-digit number for mental health and suicidal crisis is implemented.

We further recommend that public health authorities at all levels work together to deliver the resources required to implement and sustain this system nationwide. These are tasks that need to be carried out in coordination with the FCC study mandated by the National Suicide Hotline Improvements Act of 2018. It is our hope and expectation that the Commission will find the commitment that these other agencies are to make will facilitate the Commission's resolution of the numbering issue in a manner that serves the best interests of all Americans.

We greatly appreciate the FCC's efforts in establishing this proceeding and in considering our comments, and we look forward to the completed

report and the launch of a program that will serve to further the goals that Congress set out in its passage of the National Suicide Hotline Prevention Act.

Respectfully Submitted,

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